

**Please tear off this page and keep for your information.**

# **Application Information**

CHIP • PCN • UPP • Medicaid

## **What Am I Applying For?**

Health coverage is important for you and your family to get the medical care you need. When you submit this application, you will be considered for all medical programs that are now open for enrollment, including:

- **CHIP (Children's Health Insurance Program):** Provides medical and dental insurance for uninsured children in families who qualify based on family size and income.
- **PCN (Primary Care Network):** Provides primary preventive health coverage for uninsured adults who qualify based on family size and income.
- **UPP (Utah's Premium Partnership for Health Insurance):** Provides a monthly premium reimbursement when a previously uninsured individual or family enrolls in their employer's health plan or COBRA.
- **Medicaid:** Provides medical assistance for low-income families, children, pregnant women, and disabled, blind and elderly individuals.

## **What Do I Need to Do?**

- You can turn in the first 2 pages of this application to begin the application process, but you will be asked to provide the information on the rest of the application before we can determine your eligibility for benefits.
- If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. If you have not heard from DWS within 10 days, please call toll free 1-866-435-7414.
- Fill out this application and return to:  
Department of Workforce Services  
PO Box 143245  
SLC, UT 84114-3245  
Fax: 801-526-9505  
Toll-free Fax: 1-888-522-9505
- You may be asked to have your employer fill out the "Employer's Health Insurance Form" (attached). Please keep this form in case you are asked to do so.

## **Where Can I Get More Information?**

Please call the Health Information Hotline at 1-888-222-2542 or visit [www.health.utah.gov/healthservices.htm](http://www.health.utah.gov/healthservices.htm)

# Application

CHIP • PCN • UPP • Medicaid

PLEASE USE A BLACK  
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COMPLETE FORM

Case #: \_\_\_\_\_

## A Applicant Information

Name: \_\_\_\_\_  
first middle initial maiden last

Street Address: \_\_\_\_\_  
street apt. # city state zip

Mailing Address: \_\_\_\_\_  
street apt. # city state zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell/Other Phone: (\_\_\_\_) \_\_\_\_\_

E-mail: (optional) \_\_\_\_\_

## B Household Information

List all the people who live in your home. Start with yourself.

Name (first, m.i., last)	Relation to You	Social Security Number or Legal Alien ID*	Birth Date mm/dd/yy	Sex M/F	Race **	Ethnicity ***	Marital Status ****	Student Y/N	Utah Resident/ U.S. Citizen*
(Start with yourself)	self								<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen
									<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen
									<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen
									<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen
									<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen
									<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen

\*Social Security Number and citizenship information are only needed for the people applying for benefits.

\*\*Race codes: **AI**-American Indian/Alaskan Native, **AS**-Asian, **BL**-Black, **PI**-Pacific Islander, **WH**-White (You may choose more than one.)

\*\*\*Ethnicity codes: **H**-Hispanic/Latino, **N**-Non-Hispanic

\*\*\*\*Marital status: Single, Married, Divorced, Widowed, etc.

## C General Information

Please answer the following questions to help us select the program for your household.

- How many people in your household are employed? \_\_\_\_\_  
☐ Yes ☐ No
- Is anyone in your household unable to work? (injury, illness, cancer, kidney disease, etc.)  
If yes, explain: \_\_\_\_\_  
☐ Yes ☐ No
- Has anyone in your household been determined disabled by Social Security?  
If yes, who: \_\_\_\_\_  
☐ Yes ☐ No
- Has anyone in your household been in a jail, hospital or nursing home for 30 days or more within the last 3 months? If yes, explain: \_\_\_\_\_  
☐ Yes ☐ No
- Does your household have more than \$3,000 in assets? (Do not include the home you live in.)  
☐ Yes ☐ No
- Has anyone in your household received medical services in the past 90 days?  
If yes, who: \_\_\_\_\_ Dates of Service: \_\_\_\_\_  
☐ Yes ☐ No
- Is anyone in your household currently pregnant or has been pregnant in the last 90 days?  
If yes, who: \_\_\_\_\_ Due date(s): \_\_\_\_\_  
Has she smoked or used tobacco in the past 6 months? ☐ Yes ☐ No  
(This question is for survey purposes only and does **not** affect eligibility.)



- ☐ Yes ☐ No 8. Does anyone in your household have a major medical need? (This includes pregnancy/cancer/kidney disease, etc.) If yes, who: \_\_\_\_\_  
What is the medical need? \_\_\_\_\_

## **D I Understand That:**

\*The State of Utah (the State) references below include the Utah Department of Health, the Department of Workforce Services and/or the Office of Recovery Services.

- I assure that all household members applying for medical coverage or reimbursement are U.S. citizens or aliens in lawful immigration status, unless I am requesting emergency medical assistance only. I understand that I do not have to report citizenship information for household members who are not applying for coverage or reimbursement. The State will verify alien registration numbers with the U.S. Citizenship and Immigration Services (USCIS). The State will not report undocumented household members to USCIS.
- The State does not discriminate on the basis of race, ethnicity, religion, gender or disability.
- I give permission for any information provided to be verified when I apply and after I receive benefits.
- I authorize the State to give health care providers information about my eligibility for medical benefits. The State may exchange information with my health insurance carrier and/or my employer for the period I receive benefits from the program.
- I must report any changes in my address, phone number, household size and access to coverage by another health insurance program.
- The medical benefits I receive are limited to those described in the Provider Manual established for the program, as applicable. I understand that these manuals may be amended without my consent or consideration.
- The benefits I am eligible to receive may be changed without my knowledge or consent. I understand that I am responsible for any co-pays to providers at the time of medical service unless I am exempt from those co-pays.
- If I receive a medical card, I will allow only the people named on the medical card to use the card.
- I must follow the medical assistance program rules. My spouse and/or children, as applicable, also must follow these rules.
- I must cooperate with the State to establish medical support for my family and in pursuing any third party responsible for medical expenses. I must cooperate with the State to establish and collect alimony and child support for my family unless I have good cause.
- My benefits may be reduced, denied or stopped because of reported information. I understand that giving any false information or failing to report changes may result in prosecution for fraud. If I receive benefits that I am not eligible to receive, I will be responsible for repaying the benefits received.
- If the State pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the State any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the State and will hold harmless any party making payment to them.
- I may ask for a fair hearing if I disagree with the decision made on this application.
- The Utah Statewide Immunization Information System (USIIS) is a registry that keeps complete up to date records of your child's immunization history. For more information, or to withdraw your child from USIIS, call the Immunization Hotline at 1-800-275-0659.
- In the event of my death and my spouse's death, the State has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/or Medicaid at any time while I am 55 years of age or older.
- Effective January 1, 2010, the state does not have the right to recover from my estate those costs paid as a benefit of eligibility for a Medicare cost-sharing program (QMB, SLMB, QI).
- I have been given a copy of the Rights and Responsibilities and Change Reporting Requirements.

I, (print name) \_\_\_\_\_, have read or had someone read to me the statements on this page. I understand and agree to those statements. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.

Signature (check one): ☐ Applicant ☐ Authorized Representative

\_\_\_\_\_ Date

☐ Yes ☐ No I would like someone to act as an authorized representative and have access to the information regarding my case. Please send me a release form to sign and return.

**E Assets**

- ☐ Yes ☐ No 1. Do you or anyone in your household have any of the following financial assets? (Check all that apply)
- ☐ Annuities                      ☐ 401K / other retirement                      ☐ Checking Account \$ \_\_\_\_\_  
☐ IRA                                      ☐ Money Market Funds                      ☐ Savings Account \$ \_\_\_\_\_  
☐ Stocks                                      ☐ Trust Funds                      ☐ Other: \_\_\_\_\_  
☐ Bonds                                      ☐ Time Certificates
- ☐ Yes ☐ No 2. Do you or anyone in your household have any of the following assets? (Check all that apply)
- ☐ Land                                      ☐ Time Shares                      ☐ Mineral or Timber Rights  
☐ Home                                      ☐ Tools                      ☐ Livestock  
☐ Life Insurance                      ☐ Rental / Investment Property                      ☐ Other: \_\_\_\_\_  
☐ Burial Plans / Funds                      ☐ Life Estate  
☐ Campers / Trailers                      ☐ Cemetery Plots
- ☐ Yes ☐ No 3. Do you own any vehicles?
- If yes, using the chart below, list any vehicles that are owned by you and anyone who lives with you. Type of vehicle includes all cars, trucks, vans, snowmobiles, motorcycles, motor homes, boats/motors, ATV's or other vehicles.

Make	Model	Year	Licensed Y/N	License Plate #	State	Owner/Joint Owners	Amount Owed

**F Health Insurance Information**

- ☐ Yes ☐ No 1. Have you ever received medical assistance such as Medicaid or CHIP in the last 6 months?  
If yes, who: \_\_\_\_\_  
Where & when? \_\_\_\_\_
- ☐ Yes ☐ No 2. Is anyone in your household enrolled or eligible for COBRA coverage or continued health insurance through an employer?
- ☐ Yes ☐ No 3. Does anyone in your household currently have health insurance (including VA Health Care System benefits), have insurance available but not enrolled, or has had insurance in the past 6 months? If yes, please complete the chart below. (Do not list Medicaid, Medicare, CHIP or PCN)

<input type="checkbox"/> Enrolled <input type="checkbox"/> Not enrolled, but available <input type="checkbox"/> Ended, date ended: _____	Name(s) of individual(s) covered: _____
	Name of insurance company: _____ Phone #: _____
	Address of insurance company: _____ Group #: _____
	Policyholder name: _____ Policy #: _____
	Policyholder birth date: _____ Policyholder SS#: _____
	If insurance is through an employer, list employer's name and phone #: _____
	Premium cost: \$ _____ Date due: _____ How often: _____

- ☐ Yes ☐ No 4. Has anyone in your household been injured in an accident or been a victim of assault in the last 12 months?
- ☐ Yes ☐ No 5. Is someone outside of your household required to pay for medical services?
6. If you answered yes to questions 4 or 5, please fill out the following information:
- What type of incident? ☐ automobile    ☐ assault    ☐ work-related    ☐ slip/fall  
☐ medical malpractice    ☐ dog bite    ☐ other, please explain: \_\_\_\_\_
- Name of person(s) injured: \_\_\_\_\_ Who is responsible? \_\_\_\_\_
- Date of incident: \_\_\_\_\_ Was a police report filed? ☐ Yes ☐ No
- Police Department: \_\_\_\_\_ Police Report #: \_\_\_\_\_
- Name of Attorney: \_\_\_\_\_ Phone #: \_\_\_\_\_

## G Income

☐ Yes ☐ No 1. Does anyone in your household have earned income?

If yes, list any income received by all people who live in your home.

Employed Person (name)	Employer Name	Pay Rate Before Taxes (\$900/mo., \$6/hr., etc.)	Hours Worked Weekly	How Often Paid (wkly, every 2 wks, 2x mo., monthly, etc.)	Self - Employed Y/N
		/			
		/			
		/			

☐ Yes ☐ No 2. If employed, do you expect any changes in earnings or in the number of hours worked?

If yes, explain: \_\_\_\_\_

☐ Yes ☐ No 3. Do you or anyone in your household have/receive any of the following? (Check all that apply)

☐ School Financial Aid

☐ Child Support

☐ Veteran's Benefits

☐ Retirement

☐ Alimony

☐ SSI

☐ Social Security

☐ Lump Sum Payments

☐ Unemployment

What type: \_\_\_\_\_

☐ Inheritances

☐ Other: \_\_\_\_\_

☐ Worker's Compensation

☐ Settlements

☐ Yes ☐ No 4. Has anyone in your household applied for, received, or been denied Social Security Income, VA, Unemployment or Worker's Compensation?

If yes, explain: \_\_\_\_\_

☐ Yes ☐ No 5. Does anyone help you pay mortgage/rent, food, or utility bills?

If yes, explain: \_\_\_\_\_

☐ Yes ☐ No 6. Does anyone in the household work in exchange for mortgage/rent, food, or utility bills?

If yes, explain: \_\_\_\_\_

☐ Yes ☐ No 7. Does anyone in the household pay for dependent care so he/she can go to work?

If yes, list name and amount paid: \_\_\_\_\_

☐ Yes ☐ No 8. Does anyone in your household that has been determined disabled by Social Security, pay child support or alimony?

If yes, list name and amount paid: \_\_\_\_\_

## H Voter Registration Information

☐ Yes ☐ No If you are not registered to vote where you live now, would you like to apply to register to vote here today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

## I Return Completed Form To:

You have now completed the application. For more information please review the "Application Information" cover sheet. Please return this completed for to:

Department of Workforce Services  
PO Box 143245  
SLC, UT 84114-3245  
Fax: 1-801-526-9505  
Toll-free Fax: 1-888-522-9505

# **Your Rights & Responsibilities**

## **You Have the Right to:**

- Apply or re-apply any time you wish for any medical program. Applications for PCN and UPP are only accepted during open enrollment periods. If you need help, someone will help you apply.
- Receive a notice that we have either approved or denied your application and the reasons for the decision. For medical assistance, we have 30 days to process your application. We have 90 days, if you claim to be disabled, unless you need more time.
- Be notified explaining why we reduce, stop or hold your assistance. In most instances, we must mail the notice 10 days before we do this.
- Do the following things if you do not agree with decisions made regarding your case:
  - A. Talk to your worker. Make sure you are not misunderstanding each other.
  - B. Talk to your worker's supervisor.
  - C. Talk to Constituent Services: 1-801-526-4390 or call toll-free 1-800-331-4341
  - D. Request a Fair Hearing within 90 days of the decision; 10 days to get benefits while the hearing is held. If you were denied disability status, you may also ask for a reconsideration as part of the fair hearing. If SSA denied your disability, you would have to go through their appeal process.
  - E. Request legal representation regarding your fair hearing. You may be entitled to free legal assistance from Utah Legal Services. In Ogden, 1-801-394-9431 or Salt Lake, 1-801-328-8891. The toll-free number is 1-800-662-2538. You may also receive a referral for legal advice from the Salt Lake Lawyer Referral at 1-801-531-9075.
- Look at information in your case. Information about you and your case is confidential. We may give information to other agencies to administer a program to help you.

## **Your Responsibilities:**

- Verify Information - The Social Security Act (U.S.C. 1320 b - 7 (a) (1) requires that you give us a Social Security number for each household member who wants medical assistance. If you are applying only for emergency Medicaid, you do not have to provide a Social Security number. If you do not have a number, you must prove you have applied. You may be eligible for assistance while you are waiting to receive a number.

Your Social Security number will be used with the State Income and Eligibility Verification System to make sure that your household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with Job Service, Immigration and Naturalization, Social Security, and Internal Revenue Service records. We may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about your household. You must provide proof showing that you are eligible for assistance. The Department will not report undocumented household members to USCIS.

- Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS HelpLine at 1-801-538-6872 or the Immunization Hotline at 1-800-275-0659.
- Cooperate - You must cooperate in any review of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Policy. You must also cooperate in providing information about any other sources of medical payments and obtaining medical support. If you feel you could be harmed by giving this information, you can request a 'good cause' claim. Your worker can explain this procedure.

**You and your household must also follow the medical assistance program rules.**

**Please tear off this page and keep for your information.**

# **Changes You Must Report**

Remember that **YOU** are required to report changes in your situation **WITHIN 10 DAYS** of the day you learn of the change. Do not delay reporting changes. Changes can affect your eligibility. If you receive benefits which you are not eligible to receive, you will have to repay that amount.

## **If you receive Medicaid, CHIP, PCN or UPP benefits, you must report:**

- **Change in Marital Status or Living Arrangements**

Getting married, separated, or divorced; moving in with a roommate; change of address or phone number; absent parent moves in; birth of a baby or end of a pregnancy; household member moves in or out; death of a household member; hospital stays for more than 30 days; or if anyone in your household goes to jail or prison; receiving help with your household expenses, etc.

- **Change in Insurance Coverage**

Changes in access to insurance, coverage, or enrollment in any health coverage plan (including Medicare or VA Health Care System benefits) for anyone in the household. You must also report accidents or injuries which may be payable by a third party.

## **If you receive Medicaid, you must also report:**

- **Change in Source of Income**

Getting a job, terminating a job, changing jobs, working for temporary services, obtaining educational income, SSI, SSA, or unemployment compensation, etc. Receiving a lump sum. Going on strike.

- **Change in Amount of Earned or Unearned Gross Monthly Income**

Working more OR less hours, overtime, getting a raise, etc. Change in the amount of SSI, SSA, Unemployment Compensation, etc.

- **Change in the Legal Obligation to Pay Child Support**

- **Gain or Loss of a Vehicle (Licensed or Unlicensed)**

Car, truck, van, motorcycle, camper, trailer, recreational vehicle, etc.

- **Change in Any Asset(s)**

Report changes in ownership or value of stocks, bonds, property, vehicles, life insurance, trust funds, burial plans, cash, opening and closing of bank accounts, etc. for all household members. (Includes joint ownership of any asset with spouse, parents, children, etc.)

- **Change in Allowable Deductions**

Child care expenses, health insurance expenses, etc. If you are age 65 or over, blind, or disabled, you must also report changes in alimony or child support paid by a spouse or parent and work related expenses.

Case Worker \_\_\_\_\_ Phone # \_\_\_\_\_ Case # \_\_\_\_\_

PLEASE USE A BLACK  
BALL POINT PEN TO  
COMPLETE FORM

# Employer's Health Insurance Information

Case #: \_\_\_\_\_

- This form **MUST** be completed by your employer or your company's Human Resources representative. Any blanks left on this form may delay the process.
- A form must be completed for each employed household member. You may copy this form.

## A General Information

Employee Name : \_\_\_\_\_ SS#: \_\_\_\_\_

Company Name: \_\_\_\_\_ EIN: \_\_\_\_\_

☐ Yes ☐ No 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form.

☐ Yes ☐ No 2. Is the employee eligible to enroll in any insurance plan offered?

If no, please explain: \_\_\_\_\_

If yes, when is/was the employee eligible to enroll? (mm/dd/yy) \_\_\_\_\_

☐ Yes ☐ No 3. Is the employee or any family member enrolled in any insurance plan offered?

If yes, name(s) of persons enrolled: \_\_\_\_\_

☐ Yes ☐ No 4. Has this employee or any family member dropped/changed coverage in the last six months?

If yes, name(s): \_\_\_\_\_

If yes, when did coverage end/change? (mm/dd/yy) \_\_\_\_\_

## B Least Expensive Plan

Questions below refer to the **least expensive** plan offered at your company.

☐ Yes ☐ No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy) \_\_\_\_\_

3. When does the company's next open enrollment begin? (mm/dd/yy) \_\_\_\_\_

4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$ _____	\$ _____
Employee + spouse	\$ _____	_____
Employee + child	\$ _____	_____
Family	\$ _____	_____

5. Please list the yearly health plan deductible (not the "out of pocket" cost or hospital deductible).

Individual amount \$ \_\_\_\_\_ Family amount \$ \_\_\_\_\_

☐ Yes ☐ No 6. Does the plan pay for any services (doctor, pharmacy, etc.) before the employee has met the deductible listed above?

(continued)



## Employee's Health Plan Choice

Questions below refer to the plan the employee has selected. Questions 2-8 refer to "in-network" benefits.

1. Insurance company and plan name: \_\_\_\_\_
- ☐ Yes ☐ No 2. Is the deductible \$2,500 or less per individual?
- ☐ Yes ☐ No 3. Does the plan pay at least 70% of an inpatient stay (after the deductible)?
- ☐ Yes ☐ No 4. Is the lifetime maximum benefit \$1,000,000 or more?
5. What benefits are covered under this plan? (Check all that apply.)
- ☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx
- ☐ Well-child exams ☐ Child immunizations
6. Complete this chart only if it is different from the chart on the front page (section B). **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$	\$
Employee + spouse	\$	
Employee + child	\$	
Family	\$	

- ☐ Yes ☐ No 7. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s): \_\_\_\_\_
- ☐ Yes ☐ No 8. Does the plan cover abortion services?
- If yes, under what circumstances:
- ☐ Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
- ☐ Other, please describe: \_\_\_\_\_



## Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Please return completed form to:

Department of Workforce Services  
PO Box 143245  
SLC, UT 84114-3245  
Fax: 1-801-526-9500  
Toll-free Fax: 1-877-313-4717

Employee Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Case #: \_\_\_\_\_